

**WISCONSIN ROUTINE ENTERIC FOLLOW-UP WORKSHEET****PATIENT TAB**

Patient name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Gender:     M           F           Unknown

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Jurisdiction: \_\_\_\_\_

Parent's name (If child) \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_ Occupation/School: \_\_\_\_\_

**WEDSS DISEASE BEING REPORTED:**

- ☐ CAMPYLOBACTEROSIS [*Campylobacter* \_\_\_\_\_ (species)]  
☐ CRYPTOSPORIDIOSIS  
☐ E. COLI O157:H7- without HUS  
☐ E. COLI, NON-O157 SHIGA TOXIN-PRODUCING(STEC)- without HUS  
☐ GIARDIASIS  
☐ HEMOLYTIC UREMIC SYNDROME, E. coli non-O157:H7  
☐ HEMOLYTIC UREMIC SYNDROME, E. coli O157:H7  
☐ HEMOLYTIC UREMIC SYNDROME, OTHER OR UNSPECIFIED  
☐ SALMONELLOSIS [*Salmonella* \_\_\_\_\_ (serotype)]  
☐ SHIGELLOSIS [*Shigella* \_\_\_\_\_ (serogroup)]  
☐ YERSINIOSIS

Interview date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Interviewer: \_\_\_\_\_

Person interviewed: ☐ patient ☐ surrogate (specify): \_\_\_\_\_**REQUESTED SECTIONS TO BE COMPLETED DURING ROUTINE INTERVIEWS**

Exposure Period	7 days				14 days		4 days	
Disease	E.coli O157 /STECs/HUS	Salmonella	Campy	Yersina	Crypto	Giardia	Shigella	Norovirus
Enteric - Travel	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Enteric - Animal contact	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Enteric - Soil-manure exposure	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Enteric - Potential fecal exposure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Enteric - Water	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Enteric - Food source	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Enteric - Commercial food establishments	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Enteric - Large gatherings	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Enteric - Unpasteurized / Food General	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Enteric - Food history	Yes	Yes	Yes	Yes	No	No	No	No
Enteric - Dairy	Yes	Yes	Yes	No	No	No	No	No
Enteric - Meat, Poultry, Fish	Yes	Yes	Yes	Yes	No	No	No	No
Enteric - Eggs	Yes	Yes	Yes	No	No	No	No	No
Enteric - Fruit	Yes	Yes	No	No	No	No	No	No
Enteric - Vegetables	Yes	Yes	No	No	No	No	No	No
Enteric - Other foods	Yes	Yes	No	No	No	No	No	No
Enteric - Beverages	Yes	Yes	No	No	No	No	No	No

**LAB – CLINICAL TAB.** *This tab should be completed for all patients. Disease specific laboratory information is not included on this worksheet because it is unique to each agent.*

**Enteric - Symptoms**

What was the first symptom? \_\_\_\_\_

Date of symptom onset: \_\_\_\_ / \_\_\_\_ / \_\_\_\_; Time of symptom onset: \_\_\_\_ : \_\_\_\_ AM / PM

Date first well: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Symptoms:

Nausea Y N Unk

Vomiting Y N Unk

Diarrhea Y N Unk

Maximum number of stools in 24 hour period: \_\_\_\_\_

(Defined as 3 or more loose stools in a 24 hour period)

Bloody diarrhea Y N Unk

Watery diarrhea Y N Unk

Abdominal cramps Y N Unk

Chills Y N Unk

Sweats Y N Unk

Headache Y N Unk

Body/muscle aches Y N Unk

Fatigue Y N Unk

Fever Y N Unk

Highest measured temperature: \_\_\_\_\_

Other: Y N Unk

Describe: \_\_\_\_\_

**Enteric - Medical**

Did the patient have:

Hemolytic Uremic Syndrome (HUS)? Y N Unk

Thrombocytopenic Purpura (TTP)? Y N Unk

Did patient see a physician/medical provider? Y N Unk If yes, provider name: \_\_\_\_\_

Was patient hospitalized overnight? Y N Unk If yes, where: \_\_\_\_\_

Admission date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Discharge date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Did patient die as a result of this illness? Y N Unk

Does patient have any underlying medical conditions? Y N Unk

If yes, describe: \_\_\_\_\_

Did patient take any medications in 30 days PRIOR to illness onset (prescription medication, over the counter medication, herbal preparations, vitamins, or other supplements)? Y N Unk

If yes, list medications? \_\_\_\_\_

Were antibiotics prescribed FOR the illness? Y N Unk

If yes, date of first dose \_\_\_\_ / \_\_\_\_ / \_\_\_\_; List antibiotic(s) \_\_\_\_\_

Anti-diarrheal medication taken FOR this illness? Y N Unk

If yes, date of first dose \_\_\_\_ / \_\_\_\_ / \_\_\_\_; List medication(s) \_\_\_\_\_

Other medication(s) taken FOR this illness? Y N Unk

If yes, list medication(s) \_\_\_\_\_

**Enteric – Other ill persons**

Provide details--including common exposures--for household contacts, co-workers, classmates, and other associates that have a similar illness. Were others ill? Y N Unk

If yes, please describe who, when, relationship and common exposures: \_\_\_\_\_

**ENTERIC RISK TAB – See table on page 1 for additional guidance on sections to complete****Enteric Exposure period**

The exposure period should be determined based on the incubation period of the etiologic agent under investigation and the illness onset date.

*Campylobacter* – 7 days

*E. coli* (Shiga toxin producing) – 7 days

Hemolytic Uremic Syndrome – 7 days

*Salmonella* – 7 days

*Yersinia* – 7 days

*Cryptosporidium* – 14 days

*Giardia* – 14 days

*Shigella* – 4 days

Viral agents (norovirus) – 4 days

If a specific agent is not known, the exposure period should include the 7 days prior to illness onset.

Earliest exposure date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset date (end exposure): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Enteric – Travel (All patients)**

During the exposure period, did the patient travel or visit a place outside of usual activities? Y N Unk

If yes: Where: \_\_\_\_\_

Departure: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Return: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Airline/Flight No.: \_\_\_\_\_

Activities: \_\_\_\_\_

Foods consumed/Restaurants/Additional info: \_\_\_\_\_

**Enteric – Animal Contact (this section generally not necessary for Shigellosis and Viral Gastroenteritis)**

Indicate if the patient has any pets, or had contact with pets in the home of others, during the exposure period (including reptiles, pocket pets and fish). Y N Unk

If yes, list pets: \_\_\_\_\_

What brand of pet food was used & where was it purchased?: \_\_\_\_\_

Is pet fed raw meat? Y N Unk

Does patient live or work on a farm? Y N Unk

During the exposure period, did the patient have exposure to any of the following animals or their environment (including at home or visiting a farm, fair, petting zoo, school, etc) Y N Unk

Indicate all animals (or their environments) that patient had contact with during the exposure period.

☐ Dog/puppies (*circle*)

☐ Cats/kittens (*circle*)

☐ Cattle

☐ Horses

☐ Sheep

☐ Goats

☐ Pigs

☐ Poultry

☐ Fish

☐ Rodents, Specify: \_\_\_\_\_

☐ Reptiles/amphibians, Specify: \_\_\_\_\_

☐ Other, Specify: \_\_\_\_\_

Animal Contact details (Type/Location/date/type of exposure): \_\_\_\_\_

**Enteric – Soil/Manure exposure (Generally not necessary for Shigellosis and Viral Gastroenteritis)**

Did patient apply manure or compost? Y N Maybe Unk

If yes, please specify date and type of compost/manure: \_\_\_\_\_

**Enteric – Potential Fecal Exposure (All patients)**

During the exposure period, was the patient exposed to:

Adults or children using diapers? Y N M Unk -- > If yes, did the person have diarrhea? Y N M Unk

Describe the nature of the exposure (date, what type of contact with the person or diaper, etc): \_\_\_\_\_

**Enteric – Water (All patients)**

During the exposure period, was the patient exposed to the following sources of water (include drinking and recreational use):

Municipal water supply	Y	N	M	Unk	Private well	Y	N	M	Unk
Common well/Rural system	Y	N	M	Unk	Bottled water	Y	N	M	Unk
River/Lake/Pond	Y	N	M	Unk	Ocean	Y	N	M	Unk
Chlorinated pool	Y	N	M	Unk	Wading pool	Y	N	M	Unk
Water/splash park	Y	N	M	Unk	Standing water	Y	N	M	Unk

Please provide details related to your exposures (dates, locations etc) and any additional source not covered above: \_\_\_\_\_

**Enteric – Food Source (All patients)**

List grocery stores and supermarkets where patient purchased the food eaten during the exposure period.

Name: _____	Address: _____
Name: _____	Address: _____
Name: _____	Address: _____

During your exposure period, did you eat food obtained from any of the following sources?

Hunting/fishing/trapping	Y	N	M	Unk	Butcher shop	Y	N	M	Unk
Private kill	Y	N	M	Unk	Farmers market	Y	N	M	Unk
Own garden	Y	N	M	Unk	Friend/relative	Y	N	M	Unk
Home delivery (Meals on Wheels/Schwan's/Other) Y N M Unk									

Provide details regarding any "Yes" answers above (What was consumed, where and when purchased etc):

**Enteric – Food, unpasteurized/general diet (All patients)**

Tendency to buy organic or natural foods? Y N M Unk

During the exposure period, did the patient consume items or dishes containing the following items?

Unpasteurized or raw dairy products (milk, cheese, etc) Y N M Unk

If yes, specify product type/brand: \_\_\_\_\_  
 Where and when it was purchased or obtained: \_\_\_\_\_  
 Date(s) consumed: \_\_\_\_\_

Unpasteurized, raw or freshly squeezed juices? Y N M Unk

If yes, specify product type/brand: \_\_\_\_\_  
 Where and when it was purchased or obtained: \_\_\_\_\_  
 Date(s) consumed: \_\_\_\_\_

Does the patient eat a special or restricted diet? Y N Unk  
 (vegetarian, vegan, diabetic, gluten free, dairy free, infant formula and foods etc)  
 If yes, please specify: \_\_\_\_\_

### **Enteric – Commercial food establishments (All patients)**

Indicate the commercial establishments where food was eaten or obtained during the exposure period. Include restaurants, catered events, fast food, cafeterias, delis; food served in supermarkets, street vendors, concession stands, snack bars and gas stations.

Did patient eat in any establishment? Y N Unk

1. Name: \_\_\_\_\_ Address/location: \_\_\_\_\_

Meal date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ : \_\_\_\_ AM / PM

Did you eat at a salad bar or buffet at the establishment? Y N M Unk

Foods consumed: \_\_\_\_\_

2. Name: \_\_\_\_\_ Address/location: \_\_\_\_\_

Meal date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ : \_\_\_\_ AM / PM

Did you eat at a salad bar or buffet at the establishment? Y N M Unk

Foods consumed: \_\_\_\_\_

3. Name: \_\_\_\_\_ Address/location: \_\_\_\_\_

Meal date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ : \_\_\_\_ AM / PM

Did you eat at a salad bar or buffet at the establishment? Y N M Unk

Foods consumed: \_\_\_\_\_

4. Name: \_\_\_\_\_ Address/location: \_\_\_\_\_

Meal date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ : \_\_\_\_ AM / PM

Did you eat at a salad bar or buffet at the establishment? Y N M Unk

Foods consumed: \_\_\_\_\_

5. Name: \_\_\_\_\_ Address/location: \_\_\_\_\_

Meal date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ : \_\_\_\_ AM / PM

Did you eat at a salad bar or buffet at the establishment? Y N M Unk

Foods consumed: \_\_\_\_\_

### **Enteric – Large Gatherings (All patients)**

Large gathering: Wedding, shower, parties, sports events, picnics during the exposure period? Y N Unk

1. Event description: \_\_\_\_\_

Event date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ : \_\_\_\_ AM / PM

Address/location: \_\_\_\_\_

Food eaten at event: \_\_\_\_\_

2. Event description: \_\_\_\_\_

Event date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ : \_\_\_\_ AM / PM

Address/location: \_\_\_\_\_

Food eaten at event: \_\_\_\_\_

3. Event description: \_\_\_\_\_

Event date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_ : \_\_\_\_ AM / PM

Address/location: \_\_\_\_\_

Food eaten at event: \_\_\_\_\_

**Enteric – Food History (*E. coli* O157, non-O157 STECs, HUS, Salmonella, Campylobacter, Yersinia)**

Day 1 prior to Illness – Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<u>Meal</u>	<u>Ate at Home</u>	<u>Ate outside of home</u>	<u>Outside location</u>	<u>Foods eaten</u>
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dinner	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (snack etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Day 2 prior to Illness – Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<u>Meal</u>	<u>Ate at Home</u>	<u>Ate outside of home</u>	<u>Outside location</u>	<u>Foods eaten</u>
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dinner	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (snack etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Day 3 prior to Illness – Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<u>Meal</u>	<u>Ate at Home</u>	<u>Ate outside of home</u>	<u>Outside location</u>	<u>Foods eaten</u>
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dinner	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (snack etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Day 4 prior to Illness – Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<u>Meal</u>	<u>Ate at Home</u>	<u>Ate outside of home</u>	<u>Outside location</u>	<u>Foods eaten</u>
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dinner	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (snack etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Day 5 prior to Illness – Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<u>Meal</u>	<u>Ate at Home</u>	<u>Ate outside of home</u>	<u>Outside location</u>	<u>Foods eaten</u>
Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lunch	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dinner	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (snack etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

The following sections are a comprehensive food history. For each item below, ask the patient to answer “yes”, “no” or “maybe” if they remember eating the item, **either at their home or outside the home**, during their exposure period. Please remind the patient of the time frame of interest and try to obtain specific details when possible related to food items consumed.

**Earliest exposure date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Onset date (end exposure):** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Enteric – Dairy (*E. coli* O157, non-O157 STECs, HUS, *Salmonella*, *Campylobacter*)**

Item	Y	N	M	Unk	Additional information: variety or brand, purchase location, how prepared, when and where consumed etc.
Milk (pasteurized)	Y	N	M	Unk	
Sour cream	Y	N	M	Unk	
Cream cheese	Y	N	M	Unk	
Cheese	Y	N	M	Unk	Specify type:
Queso fresco (Mexican style soft cheese)	Y	N	M	Unk	Product details:
Cheese curds	Y	N	M	Unk	
Cottage cheese	Y	N	M	Unk	
Ice cream / frozen yogurt / etc	Y	N	M	Unk	
Yogurt	Y	N	M	Unk	
Any other dairy	Y	N	M	Unk	

**Enteric – Meat, Poultry, Fish (*E. coli* O157, non-O157 STECs, HUS, *Salmonella*, *Campylobacter*, *Yersinia*)**

Item	Y	N	M	Unk	Additional information: variety or brand, purchase location, how prepared, when and where consumed etc.
Ground beef / hamburger	Y	N	M	Unk	Date(s) consumed: _____ How prepared: _____ Was it raw, bloody, or pink when eaten? Y / N Where purchased/consumed: _____ Date purchased: _____ Type: (lean, %fat, chuck, round etc): _____ Size: _____lb; Purchased as pre-formed patties? Y / N Was it purchased: Fresh / Frozen; Any left-over? Y / N
Other beef (steak, roast, etc)	Y	N	M	Unk	
Chicken	Y	N	M	Unk	Date(s) consumed: _____ Describe product: _____ Where purchased/consumed: _____ Was it purchased? Fresh / Frozen Date purchased: _____
Turkey	Y	N	M	Unk	
Pork (including ham, bacon, etc)	Y	N	M	Unk	
Lamb	Y	N	M	Unk	

Fish	Y	N	M	Unk	
Shellfish / Seafood ( <i>circle</i> )	Y	N	M	Unk	
Wild game	Y	N	M	Unk	
Hot dogs / Bratwurst ( <i>circle</i> )	Y	N	M	Unk	
Sausage (other: breakfast salami, sausage, pepperoni etc)	Y	N	M	Unk	Specify:
Lunch meat (pre-packaged or deli)	Y	N	M	Unk	Specify:
Any other meat	Y	N	M	Unk	
Any above raw, rare, or under cooked?	Y	N	M	Unk	Specify:

**Enteric – Eggs (*E. coli* O157, non-O157 STECs, HUS, *Salmonella*, *Campylobacter*)**

Item	Y	N	M	Unk	Additional information: variety or brand, purchase location, how prepared, when and where consumed etc.
Eggs eaten	Y	N	M	Unk	How prepared (fried, scrambled etc): _____ Where purchased/eaten _____ Date consumed: _____
Eggs used in cooking/baking	Y	N	M	Unk	
Uncooked batter or dough eaten	Y	N	M	Unk	
Egg products/substitutes used	Y	N	M	Unk	

**Enteric – Fruit (*E. coli* O157, non-O157 STECs, HUS, *Salmonella*)**

Item	Y	N	M	Unk	Additional information: variety or brand, purchase location, how prepared, when and where consumed etc. If other than FRESH please specify.
Apples	Y	N	M	Unk	
Bananas	Y	N	M	Unk	
Cantaloupe	Y	N	M	Unk	
Cherries	Y	N	M	Unk	
Grapefruit	Y	N	M	Unk	
Grapes	Y	N	M	Unk	Red / Green
Honeydew	Y	N	M	Unk	
Oranges	Y	N	M	Unk	
Pears	Y	N	M	Unk	
Strawberries	Y	N	M	Unk	
Other berries	Y	N	M	Unk	Specify:
Watermelon	Y	N	M	Unk	
Other tree fruit (nectarines, plums, peaches, apricots)	Y	N	M	Unk	Specify:
Exotic/tropical fruit (mango, kiwi, papaya, pineapple etc)	Y	N	M	Unk	Specify:
Other citrus (lime, lemon, tangerine, Clementine)	Y	N	M	Unk	Specify:
Any other fruit	Y	N	M	Unk	Specify:



**Enteric – Vegetables (*E. coli* O157, non-O157 STECs, *HUS*, *Salmonella*)**

Item	Y	N	M	Unk	Additional information: variety or brand, purchase location, how prepared, when and where consumed etc. If other than FRESH please specify.
Packaged or bagged salads/lettuces/greens	Y	N	M	Unk	Brand: _____ Description/type: _____ Where purchased: _____ Date purchased: _____ Date(s) consumed: _____
Lettuce (that was not bagged/pre-packaged)	Y	N	M	Unk	Iceberg / Leaf / Romaine / other: _____
Spinach (loose or bagged)	Y	N	M	Unk	Describe: _____
Cabbage	Y	N	M	Unk	
Other salad greens	Y	N	M	Unk	
Asparagus	Y	N	M	Unk	
Broccoli	Y	N	M	Unk	
Carrots	Y	N	M	Unk	Baby / Regular / Pre-cut
Cauliflower	Y	N	M	Unk	
Celery	Y	N	M	Unk	
Cucumbers	Y	N	M	Unk	
Eggplant	Y	N	M	Unk	
Green onions / scallions	Y	N	M	Unk	
Other onions	Y	N	M	Unk	Specify: _____
Mushrooms	Y	N	M	Unk	
Pea pods	Y	N	M	Unk	
Peppers (sweet or hot)	Y	N	M	Unk	Specify: _____
Radishes / Jicama ( <i>circle</i> )	Y	N	M	Unk	
Sprouts (alfalfa, bean, etc)	Y	N	M	Unk	Specify: _____
Squash / Zucchini ( <i>circle</i> )	Y	N	M	Unk	
Tomatoes	Y	N	M	Unk	Specify: _____
Fresh parsley	Y	N	M	Unk	
Fresh cilantro	Y	N	M	Unk	
Other fresh herbs	Y	N	M	Unk	Specify: _____
Any other vegetable(s)	Y	N	M	Unk	Specify: _____

**Enteric – Other Foods (*E. coli* O157, non-O157 STECs, HUS, Salmonella)**

Item	Y	N	M	Unk	Additional information: variety or brand, purchase location, how prepared, when and where consumed etc.
Peanut butter	Y	N	M	Unk	
Peanuts	Y	N	M	Unk	
Any other nuts (almonds/ walnuts / pecans / etc)	Y	N	M	Unk	Specify:
Dips or spreads (hummus, Tahini, etc)	Y	N	M	Unk	Specify:
Fresh salsa	Y	N	M	Unk	
Tofu	Y	N	M	Unk	
Chocolate	Y	N	M	Unk	
Other candy	Y	N	M	Unk	Specify:
Convenience foods (ie- frozen, boxed, ready to eat)	Y	N	M	Unk	Specify:
Coleslaw	Y	N	M	Unk	
Tossed salad	Y	N	M	Unk	
Fruit salad	Y	N	M	Unk	
Potato salad	Y	N	M	Unk	
Other deli salads	Y	N	M	Unk	Specify:
Any other foods eaten	Y	N	M	Unk	

**Enteric – Beverages Enteric – Other Foods (*E. coli* O157, non-O157 STECs, HUS, Salmonella)**

Item	Y	N	M	Unk	Additional information: variety or brand, purchase location, how prepared, when and where consumed etc.
Juice (commercial/pasteurized)	Y	N	M	Unk	Specify:
Smoothies/blended drinks	Y	N	M	Unk	
Health drinks or supplements	Y	N	M	Unk	

Any additional comments or items not already covered? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_